Veterans Affairs Canada | Anciens Combattants Canada

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File No.:	Decision No.:
Service No(s).:	

Medical Questionnaire: Gastrointestinal Conditions

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Injuries? ◯ Yes ◯ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate the nature of the test/consultation, and the appointment date (if known).

Weight Change:

Pre-morbid weight _____ Current weight _____

* Pre-morbid weight is the weight before the onset of any weight loss from the pensioned/claimed gastrointestinal condition.

Is this weight change a full consequence of the pensioned gastrointestinal condition? ◯ Yes ◯ No
If no, is the weight change partially a consequence of the pensioned gastrointestinal condition? ◯ Yes ◯ No

Specify any other contributing conditions/factors, if any, and the degree to which they are responsible for the weight change:

Family name:	Given name:	File No.:

Ingestion, Maintenance of Nutrition and Excretion Conditions:

Is there any evidence of the following? Select the most appropriate description:

Ingestion: Comment (please specify complications):

- ◯ some difficulty in chewing or swallowing
- ◯ significant difficulty in chewing or swallowing
- ◯ dysphagia (1 dilation per year)
- ◯ dysphagia (2-3 dilation per year)
- ◯ dysphagia (4-5 dilation per year)
- ◯ dysphagia (6 or more dilation per year)
- ◯ other, please specify: _____

Maintenance of nutrition: Please check all that apply: Comment (please specify complications):

- ☐ malabsorption
- ☐ nutritional deficiencies
- ☐ symptoms controlled with diet/medication
- ☐ symptoms not controlled with diet/medication
- ☐ esophagostomy or gastrostomy
- ☐ ileostomy of jejunostomy
- ☐ minor diet alterations, avoids certain foods
- ☐ specific diet required (low fat, salt, cholesterol)
- ☐ prescribed exclusion diet (soft or semi-solid foods) or major diet restrictions (e.g. gluten-free diet)
- ☐ liquid or pureed diet
- ☐ other, please specify: _____

Describe any evidence of active disease. Please note local and systemic symptoms, and indicate their severity and frequency.

Excretion: Comment (please specify complications):

- ◯ occasional constipation, no treatment required
- ◯ constipation, requires occasional treatment
- ◯ persistent constipation, requires regular treatment
- ◯ fecal incontinence, associated with occasional staining, no sanitary garments required
- ◯ fecal incontinence, requires frequent changes of underwear or 1-4 sanitary garments per day
- ◯ fecal incontinence, requires >4 sanitary garments per day
- ◯ fecal incontinence, complete loss of sphincter control
- ◯ colostomy
- ◯ other, please specify: _____

Oral Cavity and Esophagus Condition:

Please describe the client's impairment.

Gastro-esophageal Reflux:

- ◯ asymptomatic hiatal hernia; no reflux
- ◯ mild or occasional, with/without hiatus hernia, no medication required
- ◯ moderate, with/without hiatus hernia, frequent minor symptoms requiring medication on most days

Esophagitis (active disease):

- ◯ daily symptoms, despite regular use of medication
- ◯ active, with complications, proven endoscopically

Esophagitis Spasm (retro-sternal pain):

- ◯ occasional symptoms, requires treatment most days
- ◯ frequent symptoms despite daily use of medication

Family name:	Given name:	File No.:

Stomach and Duodenum Condtions:

Peptic Ulcer: ☐ Not Applicable

What best describes the client's peptic ulcer condition?

- ◯ currently inactive and asymptomatic, without dietary restriction and/or medications
- ◯ necessitates occasional dietary restriction and/or occasional ulcer specific medications (prescription or non-prescription)
- ◯ frequent symptoms requiring continuous dietary restriction and regular full-dose ulcer healing prescription medications
- ◯ operated

Are there symptoms and/or complications despite strict dietary restriction and full-dose ulcer healing prescribed medication(s)? ◯ Yes ◯ No

If yes, which symptom(s)/complication(s) are experienced. Check all that apply.

- ☐ recurrent episodes of bleeding
- ☐ recurrent episodes of outlet obstruction
- ☐ persistent dumping syndrome
- ☐ other, _____ Please describe:

Dyspepsia/Gastritis: ☐ Not Applicable

Current status:

- ◯ infrequent symptoms - occasional nausea, vomiting and/or abdominal pain
- ◯ mild to moderate symptoms - frequent nausea or vomiting
- ◯ severe symptoms - daily nausea or vomiting on most days
- ◯ other, _____ Please describe:

Please describe the required treatment.

Please indicate how well the condition is controlled.

Small and Large Bowel Conditions:

Crohns disease/Ulcerative colitis: ☐ Not Applicable

Nature of condition:

- ◯ symptoms fairly well controlled with dietary and medical therapy
- ◯ moderate symptoms and some nutritional deficiencies despite dietary and medical therapy
- ◯ severe symptoms with poor response to dietary and medical therapy

Number of acute exacerbations per year: ◯ 1 ◯ 2-3 ◯ 4-5 ◯ > 5

Clients health between exacerbations:

- ◯ good
- ◯ impaired nutrition, only fair health during remissions
- ◯ no full recovery between exacerbations, pronounced nutritional deficiency, anemia requiring occasional blood transfusion, intensive treatment and increasing debility (e.g. fistulas, fever)
- ◯ continuous severe symptomatology despite ongoing intensive treatment, extensive involvement from esophagus to anus, extensive small bowel resection and adhesions

Bowel disorder: ☐ Not Applicable

Specify the condition(s): Check all that apply.

- ☐ irritable bowel
- ☐ diverticulosis
- ☐ constipation specify: ◯ occasional ◯ frequent ◯ daily
- ☐ diarrhea specify: ◯ occasional ◯ frequent ◯ daily
- ☐ abdominal pain, specify: ◯ occasional ◯ frequent ◯ daily

Treatment required: Check all that apply.

- ☐ diet
- ☐ medication

Response to Treatment:

- ◯ controlled
- ◯ partially controlled
- ◯ unresponsive

Family name:	Given name:	File No.:

Anus and Rectum Conditions:

Conditions present: Check all that apply:

- ☐ haemorrhoidal tag(s)
- ☐ haemorrohoids, internal/external — Symptoms:
  - ☐ pain — specify: ◯ occasional, or ◯ persistent
  - ☐ bleeding — specify: ◯ occasional, or ◯ persistent
  - ☐ skin maceration
  - ☐ thrombosis
  - ☐ fissures — specify: ◯ intermittent ◯ recurrent, or ◯ ongoing
- ☐ perineal fistula — Status:
  - ☐ healed
  - ☐ ongoing
- ☐ rectal absess — Status:
  - ☐ operated - no recurrence
  - ☐ recurrent - requires surgical treatment ◯ 1-2, ◯ 3-4, ◯ >4 times/ year
- ☐ anal fistula — Status:
  - ☐ healed, no discharge
  - ☐ slight/infrequent fecal discharge
  - ☐ frequent/constant fecal discharge
  - ☐ persistent/copious fecal discharge
- ☐ pruritus ani — Treatment:
  - ☐ intermittent
  - ☐ continuous, ongoing

Skin maceration/fissuring or bleeding despite ongoing treatment? ◯ Yes ◯ No

- ☐ rectal prolapse — Status:
  - ☐ mild - with constant slight or occasional moderate leakage
  - ☐ moderate - persistent or frequently recurring

Liver and Gall Bladder Conditions:

Cholecystectomy: ☐ Not applicable

- ◯ asymptomatic
- ◯ post-cholecystectomy syndrome, please describe:

Gall Bladder disease: ☐ Not applicable

List symptoms:

- ◯ asymptomatic _____
- ◯ mild symptoms _____
- ◯ moderate to severe symptoms _____

Please specify findings:

- ☐ jaundice
- ☐ gall bladder cholic
- ☐ other, _____

No. of attacks/year:

- ◯ 1-2
- ◯ 3+

Liver Disease: ☐ Not applicable

- ◯ no objective signs of liver disease; normal or mildly abnormal liver tests; good nutrition and strength.
- ◯ mildly abnormal liver function tests; clinical signs of liver disease but no history of jaundice, ascites, or bleeding episode (esophageal varix) within the past 5 years.
- ◯ abnormal liver function tests and one of the following objective signs - jaundice, ascites or 1 bleeding episode (esophageal varix) within the past 5 years.
- ◯ abnormal liver function tests and one of the following objective signs - jaundice, ascites or 1 bleeding episode (esophageal varix) within the past 1 year.
- ◯ progressive liver disease with two of the following objective signs - persistent jaundice, ascites, recurrent bleeding episodes (esophageal varix) and/or hepatic encephalopathy.
- ◯ progressive liver disease with three of the following objective signs - persistent jaundice, ascites, recurrent bleeding episodes (esophageal varix) and/or hepatic encephalopathy.
- ◯ progressive liver disease with all of the following objective signs - persistent jaundice, ascites, recurrent bleeding episodes (esophageal varix) and/or hepatic encephalopathy.

Family name:	Given name:	File No.:

Pancreas Conditions:

Pancreatic Disease: ☐ Not Applicable

- ◯ Asymptomatic
- ◯ Symptomatic

If Symptomatic, what best describes the client's condition:

- ◯ mild symptoms, 1 attack per year of typical severe abdominal pain and steatorrhea, associated with increased serum amylase; no residual pancreatic impairment.
- ◯ moderate symptoms, 2-3 attacks per year of typical abdominal pain and steatorrhea with good remission in-between.
- ◯ severe symptoms, with frequent (4-6) attacks per year of typical abdominal pain and malabsorption syndrome with steatorrhea; frequent hospital admissions within the past year.
- ◯ severe and disabling with frequent recurring attacks, more than 6 per year, of typical abdominal pain with few pain-free intermissions; steatorrhea, malabsorption, diarrhea and severe malnutrition.

Treatment:

- ☐ partial pancreatectomy
- ☐ partial relief by pancreatic enzyme supplements
- ☐ frequent hospitalizations within the last year
- ☐ total pancreatectomy (Whipples procedure)

Pancreatic Pseudocyst: ☐ Not Applicable

- ◯ managed conservatively
- ◯ required surgical decompression to adjacent structures, specify: _____

Comment:

Hernia Conditions:

Abdominal Wall Hernia: ☐ Not applicable, skip to next section.
Please describe (e.g. size, degree of protrusion, reducibility, repairability, surgical complications, etc.).

Inguinal Hernia: ☐ Not applicable, skip to next section.
Please describe (e.g. size, degree of protrusion, reducibility, repairability, surgical complications, etc.).

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Family name:	Given name:	File No.:

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:

Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No

If yes, please provide details:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

EXAMINATION FINDINGS: Describe any relevant examination findings.

IF ADLs ARE AFFECTED ON A CONTINUOUS BASIS, DESPITE OPTIMAL TREATMENT, PLEASE COMPLETE THE ADL SECTION.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)

Physician's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

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Activities of Daily Living (ADL) Questionnaire

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

IF APPLICABLE TO THE CLAIMED/PENSIONED CONDITION(S), PLEASE COMPLETE THIS SHEET

Activities of Daily Living:

Please describe the impact that the pensioned conditions have on Activities of Daily Living.

Select the description that most accurately reflects the client's current level of functioning for each of the following activities:

Activity	Independent	Independent (with aids)	Requires reminders, prompting and/or supervision in addition to minor assistance	Needs extensive assistance	Totally dependent
Eating	◯	◯	◯	◯	◯
Bathing	◯	◯	◯	◯	◯
Grooming	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Toiletting	◯	◯	◯	◯	◯
Transferring	◯	◯	◯	◯	◯

Please elaborate (list aids required, ability to sit/stand unaided during task, safety concerns, bed mobility, etc.):

Continence/Incontinence:

Select the description that most accurately reflects the client's current level of bladder and bowel control:

	Continent (No assistance needed)	Occassional nighttime incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total incontinence
Bladder	◯	◯	◯	◯	◯	◯
Bowel	◯	◯	◯	◯	◯	◯

Comment: Please note the number of incontinence pads used/day, if applicable.

Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.

Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Comments: Please remember to note other contributing conditions.

Physician's signature:	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: